

## SECTION 2

### POLICIES AND PROCEDURES

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## SECTION 2 POLICIES AND PROCEDURES

### MEDICAID DENTAL PROGRAM

#### GENERAL INFORMATION

The Medicaid Dental Program is designed to provide services for Medicaid beneficiaries from birth through the month of their 21st birthday and for Mentally Retarded/Related Disabilities (MR/RD) Waiver beneficiaries.

Dental services are defined as any covered diagnostic, preventive, therapeutic, rehabilitative, or corrective procedure. Refer to Section 4 of this manual for a comprehensive listing of covered procedures and specific guidelines. Medical justification or any referral information must be documented in the patient's medical record and must include a detailed description of services rendered. The Medicaid Dental Program does not cover services rendered for cosmetic purposes.

#### DENTAL SERVICES FOR ADULTS AGE 21 AND OVER (OPTIONAL COVERAGE GROUP)

Dental services for Medicaid beneficiaries age 21 and over are limited to emergency treatment only. Documentation supporting the emergency must be included in the beneficiary's treatment record. Multiple extractions that are non-symptomatic at the time of the service are not to be billed to South Carolina Medicaid. Extractions for convenience (*i.e.*, operating room cases, patient requests, extractions in preparation for prosthodontics, orthodontic extractions, nonrestorable nonsymptomatic teeth, periodontally involved teeth) are not to be billed to South Carolina Medicaid.

#### EMERGENCY DENTAL SERVICES

Beneficiaries over 21 years of age are eligible for limited emergency dental services only as described below:

1. Extractions for the relief of:
  - Severe and Acute pain
  - An infectious process in the mouth
2. Extractions and necessary treatment for repair of traumatic injury
3. Full mouth extractions as necessary for catastrophic illnesses such as an organ transplant, chemotherapy, severe heart disease, or other life threatening illnesses. (Full mouth extractions require prior approval from the Dental Program area)

## SECTION 2 POLICIES AND PROCEDURES

### MEDICAID DENTAL PROGRAM

#### EMERGENCY DENTAL SERVICES (CONT'D.)

Full or partial dentures to replace extracted teeth, denture adjustments, and denture reline are not Medicaid-covered services for beneficiaries over 21.

#### NOTIFICATION OF POLICY AND PROCEDURE CHANGES (MEDICAID BULLETINS)

Beginning with this manual, dental manuals can be accessed from the SCDHHS Web site at [www.scdhhs.gov](http://www.scdhhs.gov). From the home page under "Provider," click on "Provider Manuals." Provider manuals are listed in alphabetical order. The manual is updated on the Web site on the first of each month with any minor non-policy changes (*i.e.*, edit code changes, corrections to addresses, etc.). To access Medicaid bulletins on the SCDHHS Web site home page, scroll down to "News and Bulletins." Medicaid bulletins for all programs, including the dental program, are located here.

All dentists and oral and maxillofacial surgeons will still receive paper Medicaid bulletins that contain any changes in dental policies and/or procedures. Dental providers who wish to receive Medicaid bulletins electronically may e-mail **bulletin@scdhhs.gov** indicating their e-mail address(es) and contact information. If you have questions about any dental Medicaid bulletin, contact a dental program coordinator at (803) 898-2568. It is vitally important that each dental Medicaid bulletin is reviewed and shared with the dental staff and/or billing agent. If you have questions about any dental Medicaid bulletin, contact a dental program coordinator at (803) 898-2568.

#### DENTAL HYGIENIST SERVICES

Dental hygienists are not authorized to practice independently within the South Carolina Medicaid program. All services provided by a registered dental hygienist must be supervised by a dentist licensed by the state of South Carolina. The licensed supervising dentist is the authorizer of dental hygiene services.

#### Direct Supervision

Section 40-15-85 of the 1976 Dental Code as amended by Act 298 of 2000 is further amended to read: "Direct supervision" means that a dentist is in the dental office, personally diagnoses the condition to be treated, personally authorizes the procedure, and before the dismissal of the patient evaluates the performance of the auxiliary. This requirement does not mandate that a dentist be present at all times, but he or she must be on the premises and actually involved in supervision and control.

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### MEDICAID DENTAL PROGRAM

#### General Supervision

General supervision means that a licensed dentist or the DHEC public health dentist has authorized the procedure(s) to be performed but does not require that a dentist be present when the procedure(s) is performed. A dentist, licensed by and located in the state of South Carolina must supervise dental hygienists participating in DHEC's public health programs. SC Medicaid requires a supervising entity (physician, dentist, or any program that has a supervising health professional component) to be physically located in SC or within the 25-mile radius of the SC border. Procedures authorized by the supervising dentist under the public health programs must be detailed in Standing Orders to the dental hygienist and must be detailed in DHEC's approved screening system, designated as "Guidelines."

For billing purposes, claims submitted by a dental hygienist must include the authorizing/supervising dentist as identified and required in the DHEC (MOA) Memorandum of Agreement. The licensed dentist authorizing dental hygiene procedures performed under general supervision in a DHEC public health setting and pursuant to the DHEC MOA would be considered the provider of services for billing purposes and must be enrolled in the S. C. Medicaid program. SCDHHS requires that a copy of the signed DHEC MOA be submitted by September 30th of each year. Copies of any changes to the DHEC MOA must be submitted to SCDHHS within 10 days of approval by DHEC.

#### PROVIDER QUALIFICATIONS

SCDHHS requires that all state and federal requirements regarding the practice of dentistry be adhered to when providing dental services to SC Medicaid beneficiaries. In the event of a dental emergency outside the 25-mile service area radius, the treating dentist must be licensed by that state's dental board and will be required to adhere to all federal and state requirements specific to that state.

#### Enrollment

Dentists licensed by the state of South Carolina are qualified to participate in the Medicaid program. Dentists who provide emergency treatment to SC Medicaid beneficiaries outside of the 25-mile service area will be required to enroll in the SC Medicaid program to receive reimbursement. The out-of-state dental provider must be

## SECTION 2 POLICIES AND PROCEDURES

### MEDICAID DENTAL PROGRAM

#### Enrollment (Cont'd.)

licensed within that state. A dentist seeking to enroll in the SC Medicaid program must contact Medicaid Provider Enrollment at (803) 788-0222, Extension 41650 or Post Office Box 8809, Columbia, SC 29202-8809. Please direct any questions regarding the dental program and policies to the Department of Health and Human Services (SCDHHS), Department of Dental Services at (803) 898-2568.

#### National Provider Identifier (NPI)

Before enrolling with SC Medicaid, a dental provider must first obtain a National Provider Identifier (NPI) and report it on the Medicaid enrollment form. Dental providers currently enrolled in SC Medicaid must obtain an NPI and report it to SC Medicaid. Taxonomy codes must also be reported to SC Medicaid.

For information on how to obtain an NPI and taxonomy code, please see the SCDHHS NPI information page at [www.dhhs.state.sc.us/dhhsnew/serviceproviders/npi\\_info.asp](http://www.dhhs.state.sc.us/dhhsnew/serviceproviders/npi_info.asp).

The National Provider Identifier (NPI) is mandated as part of the Health Insurance Portability and Accountability Act (HIPAA) uniform health care identifier provisions. The NPI is a unique, all numeric, ten-digit number used by covered health care providers and health care provider organizations. This number is to be used in filing and processing electronic health care claims and other transactions such as eligibility inquiries and responses, claim status inquiries and responses and remittance advices. The NPI must also be used on hard copy claims.

Provider taxonomies are HIPAA standard codes that classify the type and specialization of the provider. They can be found by visiting [www.wpc-edi.com/codes/taxonomy](http://www.wpc-edi.com/codes/taxonomy). The taxonomy code used on a claim must agree with the taxonomy code the provider registered with SCDHHS.

Once you have obtained an NPI, you must share it with SC Medicaid. Any claims submitted without listing the provider's valid NPI will be rejected. You may share your NPI by visiting our Web site at [www.scdhhs.gov](http://www.scdhhs.gov) or forwarding Provider Enrollment a copy of the NPI enumeration document with the following information noted on the document: your six-digit SC Medicaid provider number, your taxonomy code, AND your zip +4 code. Mail this information to: Medicaid Provider

## SECTION 2 POLICIES AND PROCEDURES

### MEDICAID DENTAL PROGRAM

#### National Provider Identifier (NPI) (Cont'd.)

Enrollment, Post Office Box 8809, Columbia, South Carolina 29202-8809 or you can fax it to (803) 699-8637. You can also e-mail it to [provider.enrollment@bcbssc.com](mailto:provider.enrollment@bcbssc.com).

Under guidelines set forth by CMS, a contingency plan is in effect from May 23, 2007, through May 23, 2008, which allows providers to identify themselves on standard transactions and hard copy claims in one of two ways:

- **Six-character legacy Medicaid provider number and NPI:** Both the Medicaid legacy number and the NPI are used for each billing/pay-to and rendering provider on the claim. For example, do not enter the Medicaid legacy number only for one provider on the claim and the NPI only for another provider on the claim.
- **NPI only:** Only NPIs are used on the claim. The provider must ensure that NPIs used on the claim are registered with SCDHHS prior to using NPI only.

Providers are strongly encouraged to employ the dual use strategy of using both their NPI and their six-character legacy Medicaid provider number on claims. Doing this will allow SCDHHS adequate information to verify crosswalk strategy for each provider number and will ensure that accurate payments are made.

**Reminder:** It is strictly prohibited for a provider not enrolled in Medicaid to bill services under another provider's Medicaid or NPI number, including providers within the same group practices. All monies collected in this manner are subject to repayment by the provider.

Refer to Section 3, Billing Procedures, for instructions on reporting your Medicaid provider identification number(s) and your NPI(s) and taxonomy code on the claim form.

Providers may refer to the revised SC Medicaid Companion Guides for information regarding placement of the NPI and taxonomy codes. The Companion Guides are located on the SCDHHS Web site at [www.scdhhs.gov](http://www.scdhhs.gov); click on "Electronic Data Interchange" under Programs and Services, then select "SC Medicaid Companion Guide".

Effective May 23, 2007, there is one payment and one remittance advice for each NPI. This means using the same NPI for more than one current Medicaid provider number

## SECTION 2 POLICIES AND PROCEDURES

### MEDICAID DENTAL PROGRAM

#### National Provider Identifier (NPI) (Cont'd.)

will result in one payment and remittance advice/835, as opposed to a separate payment and remittance advice/835 for each current Medicaid provider number associated with that NPI. For example, physician groups that have multiple group numbers based on practice location, that choose to enumerate the group with one NPI, will receive one payment and one remittance as opposed to a payment and remittance for each practice location. If an organizational provider requires separation of payment and/or remittances, separate NPIs must be obtained and then registered with SCDHHS.

Questions regarding the NPI should be directed to your dental program representative at (803) 898-2568.

#### 1099 Tax Form

SCDHHS cannot reissue revised 1099 tax forms. SCDHHS can replace lost, stolen, or illegible 1099 tax forms with the original information only. If SCDHHS issues a 1099 in error, a re-issue will be done. You must contact your accountant to make any monetary changes regarding your Medicaid earned income. The tax information you have given to SCDHHS must match the information reported to the IRS (*i.e.*, exact name, spelling, ID numbers, etc). If it does not match, you will receive notification from SCDHHS at the end of the calendar year. You will be given a specified amount of time to make your corrections and return your tax notice to SCDHHS.

#### Extent of Provider Participation

Providers have the right to limit the number of Medicaid patients they are willing to treat within their practice; however, providers may not discriminate in selecting the Medicaid patients they will treat or services they will render. A provider may not refuse to furnish services covered under Medicaid to an individual who is eligible for Medicaid-sponsored medical assistance because of a third party's potential liability for the service(s).

A provider and a beneficiary (or the beneficiary's guardian or representative) should determine *before* treatment is rendered that the provider is willing to accept the beneficiary as a Medicaid patient. In an emergency or in situations where it cannot be determined that a patient is Medicaid eligible at the time the service is rendered, the provider should meet with the beneficiary (or the beneficiary's guardian or representative) at the earliest possible date to determine whether the provider is willing



## SECTION 2 POLICIES AND PROCEDURES

### MEDICAID DENTAL PROGRAM

#### Extent of Provider Participation (Cont'd.)

to accept the beneficiary as a Medicaid patient for the previously rendered services. *To avoid disputes or misunderstandings, providers are encouraged to document the details of their provider-patient agreement in the patient's record.*

Once a provider has accepted a beneficiary as a Medicaid patient, it is the responsibility of the provider to deliver all covered Medicaid services through the course of treatment.

SCDHHS requires that all state and federal requirements regarding the practice of dentistry be adhered to when providing services to SC Medicaid beneficiaries.

#### ORTHODONTIC SERVICES

A Medicaid beneficiary under age 21 may qualify for orthodontic services. All orthodontic referrals must be made to the local county health department to the attention of the Children's Rehabilitative Services (CRS) coordinator and must come from a physician, dentist, or other dental specialist. A referral letter must accompany the beneficiary when he or she makes application to DHEC/CRS.

**The CRS program sponsors services to children with severe craniofacial anomalies such as cleft lip and/or palate, Hemifacial or Craniofacial Microsomia, Apert's or Crouzon's syndromes, Treacher-Collins syndrome, etc. The referral must be accompanied by medical documentation indicating that the preliminary diagnosis meets these criteria. Medicaid does not reimburse for cosmetic orthodontic treatment.**

A blank copy of the Children's Rehabilitative Services Orthodontic Referral Form is located in the Forms section of this manual. A county listing containing telephone and fax numbers for the CRS coordinators is located in Section 5. Contact the CRS coordinator in the county of residence of your patient.

For additional information, write to the Department of Health and Environmental Control, Children's Rehabilitative Services, 2600 Bull Street, Columbia, SC, 29201, or call (803) 898-0784.

## SECTION 2 POLICIES AND PROCEDURES

### MEDICAID DENTAL PROGRAM

#### PHARMACY SERVICES

The following information is a guideline for writing prescriptions:

The SCDHHS maintains an “open,” or non-formulary, pharmacy services program. With certain specified exceptions, most *rebated* brand and over-the-counter **generic** pharmaceuticals are routinely covered by the Medicaid program. The Omnibus Budget Reconciliation Act (OBRA) of 1990 requires that drug manufacturers have a rebate agreement in effect with CMS in order for their pharmaceuticals to be reimbursed by the Medicaid program; therefore, only rebated pharmaceuticals that are Food and Drug Administration (FDA)-approved may be considered for reimbursement. Additionally, some pharmaceuticals (and/or quantities prescribed for certain specified drugs) require prior authorization (PA), meaning that coverage is determined through a clinical prior authorization process. For example, most *brand name* products for which therapeutically equivalent, less costly generics are available require prior authorization in order to be considered for reimbursement.

Furthermore, South Carolina Medicaid maintains a Preferred Drug List (PDL), and prescribers are strongly encouraged to write prescriptions for “preferred” products. A listing of drugs included in the PDL may be found at <http://southcarolina.fhsc.com>. However, if the prescriber deems that the patient’s clinical status necessitates therapy with a PA-required drug, the prescriber (or the prescriber’s designated office personnel) must contact First Health’s Clinical Call Center staff at 866-247-1181 (toll-free) in order to furnish detailed medical information. Approval for Medicaid coverage of drugs requiring clinical prior authorization is patient-specific and is determined according to certain established criteria. The First Health Clinical Call Center telephone number is reserved for use by health care professionals and should not be furnished to beneficiaries.

Medicare Part D prescription drug coverage applies to those beneficiaries who are dually eligible for both Medicare and Medicaid. Dual eligibles must be enrolled in one of the various Part D prescription drug plans (PDPs) approved for South Carolina in order to have their medications considered for coverage. Providers should be

## SECTION 2 POLICIES AND PROCEDURES

### MEDICAID DENTAL PROGRAM

#### PHARMACY SERVICES (CONT'D.)

aware that PDPs have different formularies, preferred drug lists, and PA programs. Prior authorization requests or general coverage questions should be directed to clinical staff within the respective PDP. Asking the beneficiary to present his or her PDP membership card may prove helpful in obtaining appropriate contact or enrollment information.

Providers are advised that the SC Tobacco Quitline, 1-800-Quit-Now (1-800-784-8669, toll-free), is available to any South Carolina resident and is not limited to Medicaid beneficiaries. The Quitline program is a free comprehensive tobacco treatment service that emphasizes a one-on-one counseling approach (using telephone and/or web-based counseling). Each caller is assigned to a personal Quit Coach who establishes a goal of working with the participant throughout the tobacco cessation process. This is an evidence-based program that has been clinically proven to help participants discontinue tobacco use for both the short and long term.

The SC Department of Health and Environment Control (SCDHEC) has developed an informational page which describes the Quitline program; copies of the information sheet may be made or downloaded from SCDHEC's website at [www.scdhec.gov/quitforkeeps](http://www.scdhec.gov/quitforkeeps). Additional information about the South Carolina Tobacco Quitline, including instructions for ordering patient education and referral materials, is available at the SCDHEC website: [www.scdhec.gov/quitforkeeps](http://www.scdhec.gov/quitforkeeps).

Beneficiaries under age 21 who have Medicaid-only coverage are allowed unlimited prescriptions per month. For beneficiaries age 21 and over, unless otherwise specifically allowed, the traditional fee-for-service Medicaid pharmacy services program sponsors reimbursement for a maximum of four prescriptions per beneficiary per month. (Note: Adult beneficiaries enrolled in the Mental Retardation/Related Disabilities [MR/RD] waiver are entitled to a core benefit of six prescriptions per month.) However, for those adult beneficiaries needing more than four (or six) prescriptions in a given month, a prescription limit override process is available for those prescriptions that meet specific criteria.

Currently, Medicaid reimburses for a maximum one-month supply of medication per prescription or refill. The

## SECTION 2 POLICIES AND PROCEDURES

### MEDICAID DENTAL PROGRAM

#### PHARMACY SERVICES (CONT'D.)

SCDHHS defines a one-month supply as a maximum 34-day supply per prescription for non-controlled substances. Providers should refer to the South Carolina Controlled Substances Regulations promulgated by DHEC for maximum quantity limitations on prescriptions for controlled substances.

For each medication dispensed (including OTCs), a valid prescription authorized by a licensed practitioner must be on file. Questions regarding this information may be directed to SCDHHS' Department of Pharmacy Services at (803) 898-2876.

## SECTION 2 POLICIES AND PROCEDURES

### DOCUMENTATION REQUIREMENTS

#### MEDICAL TREATMENT RECORD

It is necessary to maintain complete patient clinical records for Medicaid patients. Payment is contingent on medical necessity within program guidelines and supported by justifying documentation. Documentation consists of a complete and accurate treatment record and accountability of other special services. A Release of Information form signed by the child's parent or guardian authorizing the release of any medical information necessary to process Medicaid claims must be present. This is required for requesting payment of government benefits on behalf of the child. This may be incorporated into a Consent for Treatment form.

The medical treatment record is a legal document, and it must contain the patient's chief complaint, diagnosis, and documentation of services performed. No other documentation (with the exception of hospital records) will be accepted in lieu of a treatment record. This includes prior authorization forms, ledger cards, claim forms, computer records, etc. *Claims paid for Medicaid services that are not adequately documented in the medical treatment record are subject to repayment by the Medicaid provider.*

The dental provider's treatment record on each beneficiary must substantiate the need for services, including all findings and information supporting medical necessity and detailing all treatment provided. As a condition of participation in the Medicaid dental program, dental providers are required to maintain and provide access to records that fully disclose the medical necessity for treatment and the extent of services provided to Medicaid patients. SCDHHS requires that documentation (including appropriate pre- and post-treatment radiographs, copies of laboratory prescription slips and laboratory tests [*i.e.*, pathology reports]) be included in the beneficiary's treatment record. **Medicaid providers are required to maintain on site all medical and fiscal records pertaining to Medicaid beneficiaries for a period of three years.** Medicaid provider agreements and/or contracts may require differing periods of time for record

## SECTION 2 POLICIES AND PROCEDURES

### DOCUMENTATION REQUIREMENTS

#### MEDICAL TREATMENT RECORD (CONT'D.)

retention. **These requirements pertain to retention of records for Medicaid purposes only; other state and federal rules may require longer retention periods.**

#### HOSPITAL SERVICES

Procedures performed in a hospital setting require *medical justification* as part of the patient's medical record. Medical justification is based on physical or emotional handicaps, health conditions that require medical post-op monitoring, and/or complexity of procedures. **Claims paid for Medicaid services that are not adequately documented in the medical treatment record are subject to repayment by the Medicaid provider.**

The dental program at SCDHHS does not issue prior authorization numbers for hospital services for HMO beneficiaries. Dental providers must contact the general practitioner's office listed on the back of the Medicaid card to obtain a prior authorization number.

#### PRIOR AUTHORIZATION

Prior authorization shall be required for non-covered procedures that are deemed medically necessary as a result of an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) examination or any covered services that extend beyond normal limitations of that service as described in the provider manual. The following conditions and requirements apply:

- A prior authorization request must be submitted to the program area in advance of the service being performed. All required information must be present or the prior approval will be returned for completion.
- Medical documentation must accompany the prior authorization request. Dental screening services under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) examinations begin at age 1 or with eruption of first tooth and are provided every six months until age 21.
- The request must include *detailed* medical necessity documentation and radiographs applicable to the service to be rendered for review.
- Submission of a prior authorization request does not guarantee approval of the requested services. Each request will be reviewed by dental program staff and a dental consultant. If the procedure is

## SECTION 2 POLICIES AND PROCEDURES

### DOCUMENTATION REQUIREMENTS

#### PRIOR AUTHORIZATION (CONT'D.)

approved, you will receive a prior authorization approval form with an assigned prior authorization number on it. The provider will be notified in writing if the procedure is denied.

If approved, the prior authorization will be valid for that specific service, one time, and will expire one year from the date of authorization. Confirmation of the procedure does not guarantee eligibility of the beneficiary. The provider is responsible for confirming eligibility status during all phases of this process. See “Beneficiary Eligibility” in this section for more information on eligibility confirmation.

A blank Prior Authorization form (DHHS Form 214) is located in the Forms section of this manual and can be duplicated as needed. All required blocks must be completed or the request will be returned. The request must be accompanied by medical documentation reflecting justification of service(s) and must be approved by SCDHHS before a claim can be processed. You may mail your prior authorization requests to:

**SCDHHS**

Attn: Dental Department, Suite 841

Post Office Box 8206

Columbia, South Carolina 29202-8206

The prior authorized service(s) must be billed under miscellaneous procedure code D9999 (unspecified adjunctive procedure, by report) with the assigned prior authorization number listed in field 2 of the ADA claim form. Oral and maxillofacial surgeons must also submit their prior-approved services on the ADA claim form. Not using procedure code D9999, neglecting to complete field 2, and filing on the wrong claim form will result in a rejected claim.

When the ADA claim form is completed, attach a copy of the prior authorization approval form and mail it to:

**Medicaid Claims Receipt**

Post Office Box 2136

Columbia, South Carolina 29202-2136

Contact your dental program manager at (803) 898-2568 if you have questions regarding the prior authorization process or filing a claim reporting a prior approved procedure.

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### DOCUMENTATION REQUIREMENTS

#### Prior Authorization Completion Instructions

Below is an explanation of how to complete the prior authorization form. All required blocks must be completed or your request will be returned.

<b>FIELD</b>	<b>DESCRIPTION</b>
<b>2</b>	Provider name
<b>3</b>	Medicaid provider number
<b>4</b>	Your reference number, if applicable
<b>5</b>	Date submitted
<b>6</b>	Your street address
<b>7</b>	Your city, state, and zip
<b>10</b>	Beneficiary name
<b>11</b>	10-digit Medicaid beneficiary ID number
<b>12</b>	Beneficiary sex
<b>13</b>	Beneficiary birth date
<b>15</b>	Service code – Enter D9999
<b>20</b>	Your proposed charge
<b>24</b>	Service name – Enter a written description of the procedure <b>AND</b> the CPT or ADA code you would use.
<b>25</b>	Tooth number, if applicable
<b>26</b>	Tooth surface or quadrant(s), if applicable
<b>91</b>	Total proposed charge

Complete the field “Explain Medical Necessity for Each Procedure Below.” If there is not enough space, you may attach separate pages.

If you have questions regarding the prior authorization process, contact your dental program representative at (803) 898-2568.



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### DOCUMENTATION REQUIREMENTS

#### CLINICAL LABORATORY IMPROVEMENT ACT (CLIA) OF 1988

In accordance with Federal Regulation 42 CFR 492.1809, SCDHHS requires that laboratory testing sites be CLIA certified for reimbursement purposes when performing covered laboratory procedures. **For the Dental program, this only applies to oral pathology services and licensed laboratories.** Your 10-digit CLIA certificate number will be stored on your provider record with SCDHHS and does not need to be submitted on each claim form. If you have any questions concerning CLIA certification, please contact the South Carolina Department of Health and Environmental Control, Bureau of Certification, CLIA Program at (803) 545-4203.

## **SECTION 2 POLICIES AND PROCEDURES**

### **DOCUMENTATION REQUIREMENTS**

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## SECTION 2 POLICIES AND PROCEDURES

### BENEFICIARY REQUIREMENTS

#### MEDICAID IDENTIFICATION CARD

In December 2001, a permanent plastic Medicaid card was introduced to replace the monthly paper card. A separate card is issued to each Medicaid beneficiary. The 10-digit Medicaid Identification Number (Health Insurance Number) is located below the date of birth on the card. *Possession of this card does not guarantee eligibility.*

#### BENEFICIARY ELIGIBILITY

**Eligibility can be verified by calling the Medicaid Interactive Voice Response System (IVRS) toll-free at (888) 809-3040 or by using your point of sale (POS) device.** Calls to IVRS are free and limited to 10 transactions per call. Have your Medicaid Provider ID ready as well as the beneficiary's 10-digit Medicaid Identification Number. You may use the beneficiary's Social Security number if you do not have the Medicaid ID number. Refer to Section 1 for a list of vendors that can provide a point of sale device.

Providers can also verify beneficiary eligibility online via the South Carolina Medicaid Web-based Claims Submission Tool by entering the Medicaid ID, Social Security number, or a combination of name and date of birth. This is a free service. Eligibility status remains the same throughout the month, but may vary from month to month. Refer to Section 1 for detailed information regarding Medicaid eligibility.

When verifying eligibility, please listen carefully to ALL information because it may inform you of the beneficiary's eligibility in the **FAMILY PLANNING and/or MENTALLY RETARDED/RELATED DISABILITIES (MR/RD) WAIVER PROGRAMS**. If a beneficiary is in the Family Planning Waiver program, she will **not** be eligible for dental services, only for family planning services and prescriptions. IVRS will state that this beneficiary is eligible for Medicaid, and although she is eligible for Medicaid, she will not be eligible for dental services. MR/RD Waiver beneficiaries age 21 and over are eligible for the same dental services that children under age 21 receive. See a detailed explanation of these waivers in this section.

## SECTION 2 POLICIES AND PROCEDURES

### BENEFICIARY REQUIREMENTS

#### BROKEN, MISSED, OR CANCELLED APPOINTMENTS

The Centers for Medicare and Medicaid Services (CMS) prohibits billing Medicaid beneficiaries for broken, missed, or cancelled appointments. Medicaid programs are state designed, but administered by CMS under federal policies. Federal requirements mandate that providers who participate in a state's Medicaid program must accept the payment of the agency as payment in full. Providers cannot bill for scheduling appointments or holding appointment blocks. According to CMS Program Issuance Transmittal Notice MCD-43-94, broken or missed appointments are considered a part of the overall cost of doing business.

#### PREVENTIVE/ REHABILITATIVE SERVICES FOR PRIMARY CARE ENHANCEMENT (P/RSPCE), FORMERLY KNOWN AS FAMILY SUPPORT SERVICES (FSS)

P/RSPCE are goal-oriented, risk-specific interventions in a group or individual setting that address identified medical problems or needs documented in a medical plan of care. Use of P/RSPCE for monitoring of a patient's healthcare (or dental) appointments should be kept to a minimum; only beneficiaries with acute health care issues should be referred. If a Medicaid beneficiary is non-compliant with a medical treatment (*i.e.*, caries, abscess, root canal), he or she may qualify for P/RSPCE services.

A copy of the Dental Referral Form for P/RSPCE is included in the Forms section of this manual. A provider may fax or mail the referral form to a P/RSPCE provider in the beneficiary's county of residence. See the list of P/RSPCE providers in Section 5 of this manual. It is important to include the beneficiary's name, Medicaid Identification Number, and other helpful information regarding the medical non-compliance of the beneficiary.

#### MANAGED CARE ENTITIES

Dental benefits are generally not included in Managed Care programs; dental coverage and eligibility are not affected by membership in these programs.

Several of the Medicaid managed care programs do cover *adult* dental procedures not covered by the standard Medicaid dental program. For a provider to be reimbursed for these non-covered procedures, they must enroll with the HMO program and must submit claims **only** to the HMO. For beneficiaries age 21 and over, **Medicaid only covers procedures listed as adult services (A.S.) in the Dental Provider Manual.**

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### BENEFICIARY REQUIREMENTS

#### MANAGED CARE ENTITIES (CONT'D.)

If you have further questions regarding these programs, you may contact the Division of Care Management at (803) 898-4614.

#### DENTAL ELIGIBILITY WAIVER PROGRAMS

##### Family Planning Waiver

Under the Family Planning Waiver, a beneficiary is only covered for family planning services and family planning prescriptions such as birth control methods. **Dental services are not covered under this waiver.** Providers will receive the 990 edit code if they file a dental claim for Family Planning Waiver beneficiaries.

Effective January 1, 2002, Family Planning Waiver beneficiaries receive the same plastic card as all Medicaid beneficiaries. It is the responsibility of the dental provider to verify if the beneficiary is covered under the Family Planning Waiver only or if the beneficiary has full Medicaid coverage. Providers may call the Medicaid IVRS at (888) 809-3040 to verify the beneficiary's coverage. The IVRS will state whether the beneficiary is eligible for that date of service and whether she is on the Family Planning Waiver. Providers may also make a Medicaid eligibility determination from a point of sale (POS) device. If the beneficiary is on the Family Planning Waiver, this information will be located in the "special program" section and will state "Family Planning Waiver Client."

##### Mental Retardation/Related Disabilities (MR/RD) Waiver

Effective July 1, 1999, the Department of Health and Human Services, in conjunction with the Department of Disabilities and Special Needs (DDSN), allowed beneficiaries enrolled in the MR/RD Waiver program to receive the same comprehensive dental services covered for Medicaid beneficiaries under age 21. There are no additional or special procedure codes for MR/RD Waiver patients. If the procedure is not listed in the Medicaid dental provider manual, it is not a covered service for the MR/RD Waiver patient.

Many special needs or disabled beneficiaries are not enrolled in the MR/RD Waiver program. If a provider feels that a beneficiary may qualify for the services offered under the MR/RD Waiver, the provider can refer the beneficiary to the **county** DDSN office located in the

## SECTION 2 POLICIES AND PROCEDURES

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#### Mental Retardation/Related Disabilities (MR/RD) Waiver (Cont'd.)

county where the beneficiary resides. Beneficiaries should not be referred to the **state** DDSN office for enrollment, as that will only delay the enrollment process. Beneficiaries applying for enrollment in the MR/RD Waiver Program must meet specific guidelines based on their medical condition to be accepted into the program. Dental services are only a *benefit* of the waiver program, and beneficiaries age 21 and over should not apply for the MR/RD Waiver to receive dental services only. Providers also should not perform non-covered services, accept payment from the beneficiaries, and then refer the beneficiaries to the DDSN to be reimbursed for those services. The DDSN does not reimburse MR/RD Waiver clients for services received from any provider.

If the provider has questions concerning coverage of a specific dental procedure under the MR/RD Waiver, contact the dental program area at (803) 898-2568 prior to performing the service. For more information on the MR/RD Waiver program go to the DDSN Web site at [www.state.sc.us/ddsn](http://www.state.sc.us/ddsn).

#### BENEFICIARIES WITH SPECIAL HEALTH CARE NEEDS

To assist providers with treatment for children with special health care needs, the dental program offers providers the Behavior Management (D9920) procedure code. SCDHHS will reimburse for one 15-minute unit per date of service billed for extra time required to render services on patients with disabilities and/or special health care needs. SCDHHS will reimburse for this code only for children under age 21 and MR/RD Waiver beneficiaries who present themselves with disabilities and/or special health care needs (*i.e.*, mental retardation, Down syndrome, cerebral palsy, seizure disorder, heart defect, etc.) **Documentation in the patient's record must be unique to that visit and must include the description of the known condition of the patient and additional time required to provide treatment.** SCDHHS will not reimburse when this code is billed in combination with IV Conscious Sedation (D9241), Non-IV Conscious Sedation (D9248), Deep Sedation/General Anesthesia (D9220), and Analgesia, Anxiolysis, Inhalation of Nitrous Oxide (D9230). Medical records without adequate documentation are subject to repayment.

## SECTION 2 POLICIES AND PROCEDURES

### BENEFICIARY REQUIREMENTS

#### BENEFICIARY SERVICES

##### Transportation to Dental Appointments

SCDHHS provides transportation to Medicaid-covered medical/dental services through a contract with two Brokers that serve six regions in South Carolina. The guidelines for beneficiaries or their parents/guardians to schedule transportation to a dental appointment are as follows:

- The transportation request must be made three days in advance of the appointment date.
- If the appointment is for an emergency, the three-day requirement does not apply.
- Beneficiaries will need to have their Medicaid card, the name and address of dental provider, and the date and time of the appointment.
- Beneficiaries over age 21 are eligible for transportation **only** for emergency services.
- Beneficiaries must call the Broker in the county in which they reside to schedule the transportation.

Below are the contact numbers for beneficiaries to schedule transportation to a dental appointment.

**Broker: Medical Transportation Management (MTM)**

Beneficiaries in one of these counties call: **1-866-831-4130**

Abbeville	Anderson	Cherokee	Chester
Greenville	Greenwood	Lancaster	Laurens
Oconee	Pickens	Spartanburg	Union
York			

**Broker: LogistiCare**

Beneficiaries in one of these counties call: **1-866-431-9635**

McCormick	Edgefield	Saluda	Newberry
Lexington	Fairfield	Richland	

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### BENEFICIARY REQUIREMENTS

#### Transportation to Dental Appointments (Cont'd.)

**Broker: LogistiCare**

Beneficiaries in one of these counties call: **1-866-445-6860**

Aiken	Allendale	Barnwell	Bamberg
Orangeburg	Calhoun	Clarendon	Kershaw
Lee	Sumter		

**Broker: LogistiCare**

Beneficiaries in one of these counties call: **1-866-445-8915**

Berkeley	Beaufort	Charleston	Colleton
Dorchester	Jasper	Hampton	

**Broker: LogistiCare**

Beneficiaries in one of these counties call: **1-866-445-9954**

Georgetown	Horry	Marion	Marlboro
Williamsburg	Chesterfield	Darlington	Dillon
Florence			

#### Care Line

The Department of Health and Environmental Control (DHEC) renders assistance to Medicaid beneficiaries who need help in locating a participating Medicaid physician or dentist in their area. The number is 1-800-868-0404. The caller will be given a local telephone number to obtain a list of Medicaid providers in their area.

There are also lists of enrolled Medicaid providers by county and provider type on the Department of Health and Human Services' Web site at [www.scdhhs.gov](http://www.scdhhs.gov). From the home page under "Programs and Services," click on "Beneficiaries." On the next page under "Search for Providers" click on the appropriate drop-down boxes and submit. The beneficiary can contact the provider's office to inquire if they are accepting new Medicaid patients and to make an appointment.

#### FRAUD AND ABUSE

Fraud and abuse of Health and Human Services programs cost taxpayers millions of dollars each year. The vast majority of our providers and beneficiaries are honest; unfortunately, a few dishonest people can do great damage to our programs. Each dollar lost to theft is one less dollar available for someone in need of care. If you suspect



## SECTION 2 POLICIES AND PROCEDURES

### BENEFICIARY REQUIREMENTS

#### FRAUD AND ABUSE (CONT'D.)

someone of abusing the Medicaid, Child Care, or Aging programs, you should report it. There are several ways you can contact us and remain anonymous. Call the agency Fraud and Abuse Hotline at 1-888-364-3224 or write us at:

SC Department of Health and Human Services  
Attn: Fraud Investigations  
Post Office Box 100210  
Columbia, SC 29202-3210

You may e-mail us at **[fraud@scdhhs.gov](mailto:fraud@scdhhs.gov)**. Medicaid fraud and patient neglect can also be reported directly to the State Attorney General Office, Medicaid Fraud Control Unit, at 1-888-662-4328.

## **SECTION 2 POLICIES AND PROCEDURES**

### **BENEFICIARY REQUIREMENTS**

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